



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor
RICHARD M. ARMSTRONG - Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

June 1, 2011

Terese Sackos, Administrator
Amber Lane Residence - Amber Lane, Inc
1819 West Bannock Street
Boise, ID 83702

License #: Rc-744

Dear Ms. Sackos:

On April 7, 2011, a State Licensure survey was conducted at Amber Lane Residence - Amber Lane, Inc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Donna Henscheid, Health Facility Surveyor, Residential Assisted Living Facility Program, at (208) 334-6626.

Sincerely,

Donna Henscheid
Team Leader
Health Facility Surveyor
Residential Assisted Living Facility Program

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Assisted Living Facility Program



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

April 8, 2011

CERTIFIED MAIL #: 7009 0820 0000 2807 1750

Terese Sackos, Administrator
Amber Lane Residence - Amber Lane, Inc
1819 West Bannock Street
Boise, ID 83702

Dear Ms. Sackos:

Based on the Licensure and follow-up survey conducted by our staff at Amber Lane Residence - Amber Lane, Inc on **April 7, 2011**, we have determined that the facility failed to investigate skin tears and bruising of unknown origin placing residents at risk for potential abuse.

This core issue deficiency substantially limits the capacity of Amber Lane Residence - Amber Lane, Inc to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **May 22, 2011**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ What date will the corrective action(s) be completed by?

Return the **signed and dated** Plan of Correction to us by **April 21, 2011**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

Terese Sackos, Administrator
April 8, 2011

You have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Supervisor of the Residential Care Program for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**April 21, 2011**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for Licensing & Certification to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **April 21, 2011**, your request will not be granted. Your IDR request must be made in accordance with the Informal Dispute Resolution Process. The IDR request form and the process for submitting a complete request can be found at www.assistedliving.dhw.idaho.gov under the heading of Forms and Information.

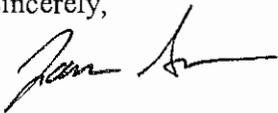
Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **May 7, 2011**.

Additionally, any variance allowing the administrator to serve over other facilities is revoked as of the date of the exit conference. The facility must now employ a single, licensed administrator who is not serving as administrator over any other facilities. Failure to do so within thirty (30) days of the date of the exit conference will result in a core issue deficiency.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Amber Lane Residence - Amber Lane, Inc.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Assisted Living Facility Program
Medicaid Licensing & Certification

JS/dh

Enclosure

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R744	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2011
NAME OF PROVIDER OR SUPPLIER AMBER LANE RESIDENCE - AMBER LANE, IN		STREET ADDRESS, CITY, STATE, ZIP CODE 1819 WEST BANNOCK STREET BOISE, ID 83702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the licensure and follow-up survey conducted on 4/4/11 through 4/7/11 at your residential care/assisted living facility. The surveyors conducting the survey were: Donna Henscheld, LSW Team Coordinator Health Facility Surveyor Gloria Keathley, LSW Health Facility Surveyor Definitions: Pt. = Patient L = Left R = Right cm = Centimeter NSA = Negotiated Service Agreement ER = Emergency Room	R 000	An investigation will be conducted & completed by May 4th, 2011, on the residents cited on survey. All findings and skin issues will be included in Resident records by May 4th, 2011.	
R 006	16.03.22.510 Protect Residents from Abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on observation, record review and interview it was determined the administrator failed to investigate skin tears and bruises of unknown origin for 2 of 3 sampled residents (#1 and #2). This failure to investigate, placed 100% of the residents at risk for potential abuse. According to IDAPA 16.03.22.520 the administrator must assure that policies and	R 006	A meeting was held with facility nurse & administrator. administrator & RN will follow-up and investigate all incidents within 24 hours of reporting. All investigation will be documented in an event report, follow-up	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Denise Smith administrator 4/21/11
(X6) DATE

STATE FORM

6589

QHRT11

If continuation sheet 1 of 6

continued "Page 3"

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R744	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2011
NAME OF PROVIDER OR SUPPLIER AMBER LANE RESIDENCE - AMBER LANE, IN		STREET ADDRESS, CITY, STATE, ZIP CODE 1819 WEST BANNOCK STREET BOISE, ID 83702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
R 006	<p>Continued From page 1</p> <p>procedures are implemented to ensure that all residents are free from abuse.</p> <p>According to IDAPA 16.03.22.011.09 an incident is defined as "An event that can cause a resident injury."</p> <p>1. Resident #1 was admitted to the facility on 3/16/11 with a diagnosis of hypertension.</p> <p>On 4/4/11 at 2:30 PM, Resident #1 was observed being brought into the front room via a wheelchair and transferred to a recliner. The resident was observed to have white guaze dressing on her right and left lower legs. She also had guaze dressings on her right forearm. She additionally was observed with a large bruise on the left forearm.</p> <p>The resident's history and physical, from an emergency room visit dated 3/29/11, documented the resident had "incredibly tender skin."</p> <p>The resident's NSA, dated 3/22/11 (not signed by the resident or family), documented the resident needed assistance with transfers and mobility. The NSA did not document the resident had specific fragile skin concerns which could result in skin tears.</p> <p>A "Physicians Verbal Order Confirmation," dated 4/3/11, documented the resident sustained a new skin tear while trying to prevent a fall during a transfer. An injury to the resident's hand occurred with "visible tendons" showing and a "large wound" to her forearm.</p> <p>"Event/Incident Reports" documented the following:</p>	R 006	<p>Community held staff in service on transferring by RN on April 15, 2011. (see attached) Patient Transferring In service for Caregivers</p> <p>Assessment will be updated & signed by family member by May 4th, 2011.</p>

Bureau of Facility Standards
STATE FORM

8899

QHRT11

If continuation sheet 2 of 8

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R744	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2011
NAME OF PROVIDER OR SUPPLIER AMBER LANE RESIDENCE - AMBER LANE, IN		STREET ADDRESS, CITY, STATE, ZIP CODE 1819 WEST BANNOCK STREET BOISE, ID 83702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 006	Continued From page 2 *3/19/11 - The resident received a 5 inch skin tear on right lower leg during a transfer. * 4/1/11 - The resident's leg rubbed against a sheet on the bed which resulted in a skin tear. It further documented the resident received the injury being transferred from the toilet to her chair. *4/2/11 - The resident's leg rubbed against the wheelchair causing her to bleed. * 4/3/11 - The resident received two skin tears, one on the top of her hand (showing tendons) and the other above the right wrist while being transferred. There was no documentation investigations had been conducted to determine the cause of injuries or to rule out abuse. Further, the facility did not implement a plan to protect the resident from further injury. "Daily Log Reports" documented the following: *3/19/11 - The resident received a skin tear to her right leg. *3/26/11 - The facility nurse instructed caregivers to send the resident to ER for infection of wounds. *4/1/11 - "... new wound on left leg below knee as staff moved her into bed, her leg caught on the sheet." *4/2/11 - During a transfer from toilet to chair the resident received a skin tear to her leg. *4/3/11 - "...two new skin tears on top of hand	R 006	and if wound is involved, a wound report. (See attached Addendum) A meeting was held with hospice addressing 1. leaving all hospice notes @ community prior to leaving. 2. Documentation of follow-up on existing wounds will be designated as such so NOT to be confused as a "new wound" each visit. completed by May 4th, 2011	

Bureau of Facility Standards
STATE FORM

6899

QHRT11

If continuation sheet 3 of 6

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R744	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2011
NAME OF PROVIDER OR SUPPLIER AMBER LANE RESIDENCE - AMBER LANE, INI		STREET ADDRESS, CITY, STATE, ZIP CODE 1819 WEST BANNOCK STREET BOISE, ID 83702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 006	<p>Continued From page 3</p> <p>and the other is above the wrist."</p> <p>The following "Nurse Assessment Form" documented the following:</p> <p>*3/26/11 - "Skin tear assessed. Appears to be infected...Sent to ER."</p> <p>*4/1/11 - "...new skin tear on left lower leg. Caregiver used pressure to stop bleeding."</p> <p>*4/2/11 - "Assessed new skin tear to left lower leg, direct pressure to stop bleeding."</p> <p>*4/3/11 - "...significant skin tear to wrist. Resident was sitting on the toilet and not doing anything with her hands. Skin simply separated and exposed tissue."</p> <p>The "Event/Incident Report," dated 4/1/11, refers to two separate injuries but only one injury was noted by the contracted agency nurse. Further, the "Event/Incident Report," dated 4/3/11, was not congruent with the documentation from the contracted agency nurse. The incident stated the injury occurred during a transfer but the nursing documentation stated the resident was doing nothing, the "skin simply separated." There was no documentation that an investigation of either incident was conducted to determine exactly how the injuries occurred.</p> <p>2. Resident #2 was admitted to the facility on 8/26/10 with diagnoses including Alzheimer's disease and history of a stroke.</p> <p>An "Event/Incident Report," dated 11/2/10, documented the resident was left unattended on the toilet. When the caregiver returned, a small skin tear was found on the resident's left middle</p>	R 006		

Bureau of Facility Standards
 STATE FORM

8899

QHRT11

If continuation sheet 4 of 6

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R744	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2011
NAME OF PROVIDER OR SUPPLIER AMBER LANE RESIDENCE - AMBER LANE, IN		STREET ADDRESS, CITY, STATE, ZIP CODE 1819 WEST BANNOCK STREET BOISE, ID 83702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 006	<p>Continued From page 4</p> <p>finger. The resident was unable to state how it occurred. The report was not signed by the administrator and there was no documentation an investigation had been conducted to determine the cause of the unknown bruising.</p> <p>Hospice "Ongoing Comprehensive Nursing Assessment" forms documented the following:</p> <p>*12/31/10 - "Pt also has multiple bruises on hands"</p> <p>*1/28/11 - "...some bruising on hands"</p> <p>*2/8/11 - "...leg (L) lower skin has 2.5 cm skin tear in the shape of a C... Staff unsure how pt obtained skin tear."</p> <p>*2/11/11 - "...bruising on hands bilaterally, skin tear (L) elbow and (L) lower leg. Elbow 0.5 cm (L) and left lower leg 1 cm... Staff unsure how or when she received bruising."</p> <p>*2/17/11 - "Skin tear lower leg and on arm"</p> <p>*2/18/11 - "(L) elbow, small closed red area, 2 small 1.5 cm areas on (L) lower leg"</p> <p>*3/11/11 - "(L) scab healing well. Tear on (L) lower leg 2 cm x 4 cm.</p> <p>*4/4/11 - " 2 small 0.5 cm diameter areas on (L) leg healing well."</p> <p>There were no "Event/Incident Reports" or daily log notes found in the resident's record regarding any incidents that may have coincided with the above injuries. Further, there was no documentation an investigation had been conducted to determine the cause of the unknown bruising and skin tears.</p> <p>On 4/4/11 at 1:15 PM a caregiver stated the resident had a wound on her right lower leg. The caregiver stated the wound had "been there so long" she was not sure if it was a skin tear or just an open area.</p>	R 006		

Bureau of Facility Standards
STATE FORM

8899

QHRT11

If continuation sheet 5 of 6.

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R744	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2011
NAME OF PROVIDER OR SUPPLIER AMBER LANE RESIDENCE - AMBER LANE, IN		STREET ADDRESS, CITY, STATE, ZIP CODE 1819 WEST BANNOCK STREET BOISE, ID 83702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 006	Continued From page 5 On 4/7/11 at 9:40 AM, a caregiver was asked to provide documentation regarding the incidents that occurred from 12/1/10 through present regarding Resident #2. The caregiver confirmed there were no "Event/Incident Reports" found during the requested timeframe. The facility administrator was out of town during the survey and failed to appoint a designee to act on her behalf. There was no documented evidence the facility administrator conducted investigations of residents found with bruising and skin tears. By not conducting a thorough investigation, the facility could not identify the source of the injury to rule out possible abuse.	R 006		

Bureau of Facility Standards
STATE FORM

8899

QHRT11

If continuation sheet 8 of 6



ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Amber Lane Residence	Physical Address 1819 W. Bannock St.	Phone Number 208-336-5004
Administrator Terese Sackos	City Boise	Zip Code 83702
Team Leader Donna Henscheid	Survey Type Licensure and Follow-up	Survey Date 04/07/11

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
1	152.05.b.iii	2 of 3 sampled residents and one random resident had bedrails.	4-27-11	5/6/11 DH
2	215.10	The administrator did not appoint, in writing, a designee to assume responsibility for the facility during her absence.	4-27-11	5/6/11 DH
3	225	Residents #2 and #3 did not have a behavior management plan to include an evaluation and interventions.	4-27-11	5/6/11 DH
4	250.10	The facility hot water temperatures exceeded 120 degrees.	4-09-11	5/6/11 DH
5	300.01	The facility RN had not assessed Resident #2 after bruising and skin tears were noted.	4-28-11	5/6/11 DH
6	320	Resident #1's NSA was not signed and dated by all parties. Resident #2's NSA was not updated to include toileting, mobility, transfer, pureed diet, and frequency of services from hospice. #1 (resolv. 4-4-11) #2 4-27-11	4-27-11	5/6/11 DH
7	325.03	The facility did not follow correct infection control procedures when they did not provide liquid hand soap or paper towels in residents' rooms for those residents requiring assistance with cares.	4-28-11	5/6/11 DH
8	451.01.d	There was no documentation of substitutions made to the menu. (correct on site)	4-27-11	5/6/11 DH
9	451.03.	The facility did not serve a random resident a therapeutic diet approved by a dietitian.	5-03-11	5/6/11 DH
10	711.01	The facility did not document/track behaviors to provide information to the physician for psychotropic reviews.	4-27-11	5/6/11 DH
11	711.08.c	The facility did not document Resident #2's incidents regarding skin tears and bruising.	4-27-11	5/6/11 DH
12	730.01.f	The facility did not maintain employee records to include CPR, First Aid and medication certification.	4-27-11	5/6/11 DH
13	730.01.h	Two staff members did not have documentation of delegation.	4-27-11	5/6/11 DH
Response Required Date 05/07/11	Signature of Facility Representative 		Date Signed 5-03-11	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

MEDICAID LICENSING & CERTIFICATION - RALF
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

reset form print form

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name Amber Lane Residence	Physical Address 1819 W. Bannock St.	Phone Number 208-336-5004
Administrator Terese Sackos	City Boise	Zip Code 83702
Team Leader Donna Henscheid	Survey Type Licensure and Follow-up	Survey Date 04/07/11

NON-CORE ISSUES

Item #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	L&C USE
14	305.05	The facility nurse did not follow-up on previous recommendations made regarding Resident #1's change in conditions. For example: The nurse referred the resident to the hospital for treatment and made recommendations for wound care.	4-28-11	<i>PH</i>
		See attached supporting documentation.		

Response Required Date 05/07/11	Signature of Facility Representative <i>Donna Henscheid</i>	Date Signed 5-03-11
------------------------------------	----------------------------------------------------------------	------------------------



IDAHO DEPARTMENT OF

HEALTH & WELFARE Food Establishment Inspection Report

Food Protection Program, Division of Health
450 W. State Street, Boise, Idaho 83720-0036
208-334-5938

Establishment Name <u>Amber Lane Residence</u>		Operator <u>Terese Sackos</u>	
Address <u>1919 W. Bannock St</u>		City/Zip <u>Boise 83702</u>	
County <u>Ada</u>	Estab #	EHS/SUR.#	Inspection time: _____ Travel time: _____
Inspection Type:	Risk Category: <u>High</u>	Follow-Up Report: OR	On-Site Follow-Up: Date: _____ Date: _____
Items marked are violations of Idaho's Food Code, IDAPA 16.02.19, and require correction as noted.			

# of Risk Factor Violations	<u>1</u>	# of Retail Practice Violations	_____
# of Repeat Violations	_____	# of Repeat Violations	_____
Score	<u>+</u>	Score	_____
A score greater than 3 Med or 5 High-risk = mandatory on-site reinspection		A score greater than 6 Med or 8 High-risk = mandatory on-site reinspection.	

RISK FACTORS AND INTERVENTIONS (Idaho Food Code applicable sections in parentheses)

The letter to the left of each item indicates that item's status at the inspection.

	Demonstration of Knowledge (2-102)	COS	R
<u>Y</u> N	1. Certification by Accredited Program, or Approved Course; or correct responses; or compliance with Code Employee Health (2-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	2. Exclusion, restriction and reporting	<input type="checkbox"/>	<input type="checkbox"/>
Good Hygienic Practices			
<u>Y</u> N	3. Eating, tasting, drinking, or tobacco use (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	4. Discharge from eyes, nose and mouth (2-401)	<input type="checkbox"/>	<input type="checkbox"/>
Control of Hands as a Vehicle of Contamination			
<u>Y</u> N	5. Clean hands, properly washed (2-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	6. Bare hand contact with ready-to-eat foods/exemption (3-301)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	7. Handwashing facilities (5-203 & 6-301)	<input type="checkbox"/>	<input type="checkbox"/>
Approved Source			
<u>Y</u> N	8. Food obtained from approved source (3-101 & 3-201)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	9. Receiving temperature / condition (3-202)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	10. Records: shellstock tags, parasite destruction, required HACCP plan (3-202 & 3-203)	<input type="checkbox"/>	<input type="checkbox"/>
Protection from Contamination			
<u>Y</u> N <u>N/A</u>	11. Food segregated, separated and protected (3-302)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/A</u>	12. Food contact surfaces clean and sanitized (4-5, 4-6, 4-7)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	13. Returned / reservice of food (3-306 & 3-801)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	14. Discarding / reconditioning unsafe food (3-701)	<input type="checkbox"/>	<input type="checkbox"/>

	Potentially Hazardous Food Time/Temperature	COS	R
<u>Y</u> N <u>N/O</u> <u>N/A</u>	15. Proper cooking, time and temperature (3-401)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	16. Reheating for hot holding (3-403)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	17. Cooling (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	18. Hot holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	19. Cold Holding (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	20. Date marking and disposition (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N <u>N/O</u> <u>N/A</u>	21. Time as a public health control (procedures/records) (3-501)	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Advisory			
<u>Y</u> N <u>N/A</u>	22. Consumer advisory for raw or undercooked food (3-603)	<input type="checkbox"/>	<input type="checkbox"/>
Highly Susceptible Populations			
<u>Y</u> N <u>N/O</u> <u>N/A</u>	23. Pasteurized foods used, avoidance of prohibited foods (3-801)	<input type="checkbox"/>	<input type="checkbox"/>
Chemical			
<u>Y</u> N <u>N/A</u>	24. Additives / approved, unapproved (3-207)	<input type="checkbox"/>	<input type="checkbox"/>
<u>Y</u> N	25. Toxic substances properly identified, stored, used (7-101 through 7-301)	<input type="checkbox"/>	<input type="checkbox"/>
Conformance with Approved Procedures			
<u>Y</u> N <u>N/A</u>	26. Compliance with variance and HACCP plan (8-201)	<input type="checkbox"/>	<input type="checkbox"/>

Y = yes, in compliance N = no, not in compliance
 N/O = not observed N/A = not applicable
 COS = Corrected on-site R = Repeat violation
 = COS or R

Item/Location	Temp	Item/Location	Temp	Item/Location	Temp	Item/Location	Temp
<u>Cottage Cheese / Fridge</u>	<u>41</u>	<u>Salmon / Spiced</u>	<u>160.9</u>				
<u>Lima Beans / Fridge</u>	<u>41</u>						

GOOD RETAIL PRACTICES (input X = not in compliance)

	COS	R		COS	R		COS	R
<input type="checkbox"/> 27. Use of ice and pasteurized eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34. Food contamination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42. Food utensils/use	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 28. Water source and quantity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35. Equipment for temp control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43. Thermometers/Test strips	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 29. Insects/rodents/animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36. Personal cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44. Ware washing facility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 30. Food and non-food contact surfaces: constructed, cleanable, use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37. Food labeled/condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45. Wiping cloths	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 31. Plumbing installed, cross-connection, back flow prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38. Plant food cooking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46. Utensil & single-service storage	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 32. Sewage and waste water disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39. Thawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47. Physical facilities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 33. Sinks contaminated from cleaning maintenance tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40. Toilet facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48. Specialized processing methods	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/> 41. Garbage and refuse disposal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 49. Other	<input type="checkbox"/>	<input type="checkbox"/>

OBSERVATIONS AND CORRECTIVE ACTIONS (CONTINUED ON NEXT PAGE)

Person in Charge (Signature) <u>Terese Sackos</u> (Print)	Title	Date <u>4-7-11</u>
Inspector (Signature) <u>Chloris Kethy</u> (Print)	Date <u>4-7-11</u>	Follow-up: (Circle One) <u>Yes</u> <u>No</u>



Food Establishment Inspection Report

Page 2 of 2
Date 7-10-11

Establishment Name <u>Amber Lane Residence</u>	Operator <u>Terese Sackos</u>
Address <u>1719 W. Bannock St</u>	<u>Boise 83702</u>
County Estab # <u>Ada</u>	EHS/SUR.# License Permit #

OBSERVATIONS AND CORRECTIVE ACTIONS (Continuation Sheet)

#20 - The facility was not date marking food in fridge - COS - Facility educated on the importance of date marking all foods & date

10/1/11

Person in Charge <u>Leticia A. Buss</u>	Date <u>4-7-11</u>	Inspector <u>[Signature]</u>	Date <u>4-7-11</u>
--------------------------------------------	-----------------------	---------------------------------	-----------------------